STANDING COMMITTEE

ON

MEDICAL MANPOWER

ANNUAL REPORT
1987

Manitoba
Health Services
Commission

April 1, 1988

The Honourable Wilson Parasiuk
Minister of Health
358 Legislation Bulding
450 Broadway Avenue
Winnipeg, Manitoba
R3C 0V8

Dear Mr. Parasiuk:

I have the honour to submit the annual report of the Standing Committee on Medical Manpower for 1987.

The Standing Committee on Medical Manpower was constituted in 1979 "for the purpose of review, analysis, evaluation and recommendations with respect to all matters bearing on the supply, category of practice and geographic distribution of physicians in Manitoba".

Three all day meetings of the full committee were held in Winnipeg during the year. Comprehensive minutes of these meetings are available should you wish to examine them.

Between general meetings, subcommittees performed the committee's functions and implemented its recommendations.

The committee wishes to express its appreciation to all those who helped with its work.

I wish to thank all members of the committee personally for their conscientious consideration of the issues addressed in this report.

Respectfully submitted,

J. C. Wilt, M.D.
Interim Chairman
Standing Committee on Medical Manpower

/bk

April 1, 1988

The Honourable Roland Penner
Minister of Education
168 Legislation Building
450 Broadway Avenue
Winnipeg, Manitoba
R3C 0V8

Dear Mr. Penner:

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INDEX

Introduction 1

Members 2
Meetings 3
Subcommittees 3
Other Working Committees 3
Function of the Secretariat 6

Physician Supply

National 7
Manitoba 8

Women in Medicine 12

The Need For Physicians 13

The Urban Oversupply 16

Specialty Services to Rural Manitoba

Radiological Services 17
Psychiatric Consultative Services 18
Anesthesia Services 18

Incentive Programs 20

Rural Student Recruitment 20
Work Experience - First and Second Year Students 20
Loans to Third and Fourth Year Students 22
Family Medicine - Community Medicine Rotation 22
Rural Residency Program for Practicing Physicians 23
Family Practice Residency Program - Rural Rotation 23
Incentive Grants to Physicians Commencing Practice in a Designated Medically Underserviced Area 23

Evaluation of Incentive Programs 24

Placement Services 26

Locum Tenens 26

Immigration Policies 27

Refugee Physicians Training Program 29

Schedule of Expenditures 31

Appendices - Memoranda of Agreement

INTRODUCTION

The Standing Committee on Medical Manpower, established in 1979, reports to the Ministers of Health and Education and, as stated in the Ad Hoc Committee on Medical Manpower report dated April 19, 1978, was constituted "for the purpose of review, analysis, evaluation and recommendations with respect to all matters bearing on the supply, category of practice and geographic distribution of physicians in Manitoba".

The major problems, identified by the Ad Hoc Committee on Medical Manpower in 1978, however, were shortages of medical services in rural and remote Manitoba and the Standing Committee up to now has focused mainly on shortages and maldistribution of physicians in these areas.

Circumstances have changed with time and equally important problems now exist in the urban areas where an oversupply of some types of physicians and under-supply in certain specialties have manifested themselves. The Committee perceives that one important solution to the problems of both rural and urban manpower supply lies with the re-organization of the health systems, i.e., shared services arrangements and resources between the regions.

Committee members represent the Manitoba Health Services Commission, the Department of Health, the Universities Grants Commission, the College of Physicians and Surgeons of Manitoba, the Manitoba Medical Association, the Faculty of Medicine, University of Manitoba, the Professional Association of Residents and Interns of Manitoba, the Manitoba Health Organizations, Inc., University Grants Commission, the Union of Manitoba Municipalities, the Manitoba Association of Urban Municipalities, and other groups concerned with physician manpower.

Members report regularly to their organizations and relay to the Committee the views of their colleagues.

Close, informal liaison is maintained with Mr. T. R. Edwards, C.A., Deputy Minister of Health and Executive Director of the Manitoba Health Services Commission.

MEMBERS:

J. C. Wilt, M.D.	Interim Chairman, Standing Committee on Medical Manpower
M. J. Painchaud,	Executive Secretary, Standing Committee on Medical Manpower
K. M. Simpson, M.D.,	College of Physicians and Surgeons of Manitoba (from December 2, 1986)
B. D. Postl, M.D.,	University of Manitoba
F. Steinberg, M.D.,	Professional Association of Residents and Interns, Manitoba (PARIM) (to March 31, 1987)
B. Wright, M.D.,	Professional Association of Residents and Interns, Manitoba (PARIM) (from April 1, 1987)
R. J. Boyd, M.D.,	Manitoba Medical Association
G. Dow, M.D.,	Manitoba Medical Association
G. Gelowitz,	Manitoba Health Organizations, Inc.
H. J. Gilmour,	Manitoba Association of Urban Municipalities (to March 1, 1987)
A. Goldstein,	Universities Grants Commission (to June 4, 1987)
B. Levin, M.D.,	Universities Grants Commission (from June 5, 1987)
J. Neufeld,	Union of Manitoba Municipalities (to January 20, 1987)
T. Arnason	Union of Manitoba Municipalities (from January 21, 1987)

RESOURCE CONSULTANTS:

Mrs. V. MacKay	Director, Rural Facilities, Manitoba Health Services Commission (to August 28, 1987)
J. Lock	A/Director, Rural Facilities, Manitoba Health Services Commission (from August 31, 1987)
T. Williams, M.D.,	Laboratory and X-ray Services, Manitoba Health Services Commission
D. Pascoe,	Director, Research and Planning, Manitoba Health

MEETINGS:

During 1987, the Standing Committee on Medical Manpower met three times in all-day sessions to consider a variety of medical manpower issues. The day to day activities of the Committee are carried out by the Secretariat.

SUBCOMMITTEES:

Subcommittees met at frequent, but irregular intervals at the discretion of the Chairman. These are:

Liaison Subcommittee with the Faculty of Medicine, University of Manitoba

Subcommittee on Public Health

Subcommittee on Shared Services

Subcommittee on Placement

Subcommittee on Anesthesia

Subcommittee on Underserviced Area Program

Subcommittee on Criteria for Underserviced Areas

Subcommittee on Incentive Programs

Subcommittee on Radiological Services

OTHER WORKING COMMITTEES:

A) Working Committee on Medical Manpower

A working committee was established by the Minister of Health in March 1987 to discuss the serious concerns with regards to the pressures placed on the health delivery system, namely

i) the maldistribution of physicians by specialty and by urban/rural location;

ii) the increasing number of walk-in clinics, and

iii) the on-going increase in the volume of medical services.

The Committee, composed of representation from the medical profession (the College of Physicians and Surgeons, the Faculty of Medicine - University of Manitoba, the Manitoba Medical Association, the Manitoba Medical Students Association, and the Professional Association of Interns and Residents of Manitoba) and government representatives, met on three occasions and filed the following conclusions with the Minister of Health on April 23, 1987.

a) the number of students enrolled in 1st year medicine be reduced from the current eighty-five (85) students to eighty (80) in September 1987, and further reduced to seventy-five (75) in September 1988 with the proviso that one or two additional positions be retained for the Special Pre-Medical Studies program;

b) there would be a negotiated reduction in resident positions;

c) the Faculty of Medicine, through its Northern Medical Unit Division, would work with SCOMM to achieve the recruitment of Manitoba and/or Canadian graduates to rural and remote practices and, thus, to limit the dependency on foreign medical graduates;

d) the on-going increase in the volume of fee-for-service billings is an issue that can primarily be dealt with at MMA/MHSC negotiating table;

e) that SCOMM's responsibilities be expanded to provide an on-going mechanism for comprehensive province-wide medical manpower planning.

B) Working Group on Rural Recruitment

A working group on rural placement was established in May 1987 by SCOMM and has been working with ways and means of enhancing recruitment to rural and remote areas of the province. It is the general consensus that recruitment to these areas will not improve until such time as the matter of regionalization or shared services arrangements are put in place as well as other innovative ideas are introduced.

Represented on the working group is the University of Manitoba - Faculty of Medicine, Northern Medical Unit, the Post-graduate Medical Education, Department of Family Medicine, Professional Association of Residents and Interns of Manitoba and the Standing Committee on Medical Manpower. The Committee met on six occasions during 1987.

FUNCTIONS OF THE SECRETARIAT:

The secretariat implements recommendations of the Standing Committee on Medical Manpower and its subcommittees on a continuing basis and also maintains close liaison with the following:

- Department of Family Medicine, Faculty of Medicine, University of Manitoba, concerning the incentive programs for first and second year medical students and the post-graduate residency program for family physicians.

- The Committee on Post-Graduate Medical Education, Faculty of Medicine, University of Manitoba, concerning the rural residency incentive program.

- The College of Physicians and Surgeons, responsible for registration and licensure of physicians in Manitoba.

- Employment and Immigration Canada, which refers all requests for entry of foreign physicians to Manitoba for approval of the secretariat.

- Rural communities to determine local needs.

- Physicians in rural communities where additional manpower is required.

- Students showing interest in the incentive programs.

- The Manitoba Medical Association.

- Physicians seeking job opportunities in Manitoba.

PHYSICIAN SUPPLY

National

The number of active physicians in Canada[1], excluding residents and interns, has increased 25.11 percent, from 36,444 (18,000 specialists, 18,444 general and family physicians) on December 31, 1979 to 45,594 (22,061 specialists, 23,533 general and family physicians) on December 31, 1986.

The ratio of physicians to population in Manitoba is shown in Table I.

TABLE I

Population per Active[1] Civilian Physician, Canada, by Province[2]

	All Physicians Excluding Interns and Residents		All Physicians Including Interns and Residents	
	Dec. 31/86	Dec. 31/85	Dec. 31/86	Dec. 31/85
Newfoundland	684	738	556	596
Prince Edward Island	737	790	724	775
Nova Scotia	578	586	485	489
New Brunswick	845	820	775	753
Quebec	530	542	453	459
Ontario	549	562	462	469
Manitoba	**583**	**595**	**491**	**497**
Saskatchewan	718	729	627	628
Alberta	654	678	552	567
British Columbia	510	511	469	471
Yukon	814	811	814	811
Northwest Territories	1,089	1,273	1,089	1,273
Canada	565	577	484	491

[1]In producing statistical reports based on Southam Medical Data Base (SMDB), the Department of National Health and Welfare has combined "not-in-private-practice" and "active" physicians into a group entitled "Active Civilian Physicians". This group includes registered and non-registered physicians in research, administration, teaching and physicians in clinical practice.

[2]Health Information Division, Department of National Health and Welfare, Ottawa, Ontario - March 1987.

The foregoing figures are a less precise gauge of physician manpower than the Manitoba Health Services Commission Physicians Registry or the rolls of the licensing agent, the College of Physicians and Surgeons of Manitoba.

The Manitoba Health Services Commission funds 336.5 residents and interns. In addition, there are 34.8 full-time equivalent Fellows and residents externally funded. One hundred and sixty-one (161) residents are not included in the registration figures of the College of Physicians and Surgeons as they have taken out a license for residency duties only. Figures supplied by the College of Physicians and Surgeons include some retired and semi-retired physicians as they still hold a license to practice.

Manitoba

TABLE II

Number of Licensed Medical Practitioners in Manitoba[2]

Year	Winnipeg	%	Outside Winnipeg	%	Total	Net Gain or Loss
1976	1,237	74.5	423	25.5	1,660	+79
1977	1,264	74.9	424	25.1	1,688	+28
1978	1,263	74.9	424	25.1	1,687	- 1
1979	1,269	75.3	417	24.7	1,686	- 1
1980	1,276	75.3	419	24.7	1,695	+ 9
1981	1,323	76.1	416	23.9	1,739	+44
1982	1,379	75.9	437	24.1	1,816	+77
1983	1,424	77.3	419	22.7	1,843	+27
1984	1,476	76.8	445	23.2	1,921	+78
1985	1,520	77.2	449	22.8	1,969	+48
1986	1,577	77.8	449	22.2	2,026	+57
1987	1,574	78.1	443	21.9	2,017	- 9

[2]College of Physicians and Surgeons, Manitoba, Vol. 23, No. 6, September 1987

The total of 2,017 mentioned in Table II includes 89 fully licensed residents, some of whom "moonlight". If these 89 are deleted as "not in active practice" as well as the 43 life members who are "not in active practice," there would be a net of 1,885 "active" physicians compared to 1,900 in the previous year.

TABLE III

Distribution of Medical Practitioners by
Country of Qualification as of July 31, 1987[3]

	Origin	Winnipeg	Brandon	Rural	Residency
TOTAL		1,574	93	350	161
	(%) Manitoba	57.6	35.5	43.7	58.4
	(%) Canada	12.6	13.9	8.2	31.0
	(%) USA	.4	.0	.0	.6
	(%) United Kingdom and Ireland	14.4	27.9	28.3	5.6
	(%) Europe	3.4	2.2	4.6	1.9
	(%) Asia	7.7	12.9	7.7	2.5
	(%) Australia/New Zealand	1.1	1.1	.9	.0
	(%) Africa	1.4	4.3	6.6	.0
	(%) South America	1.4	2.2	.0	.0

[3]College of Physicians and Surgeons, Manitoba
Registrar's Report - September 18, 1987

Table III illustrates that of the 1,574 practitioners in Winnipeg, 57.6 percent are graduates of the University of Manitoba, 12.6 percent are graduates of other Canadian universities, and 29.8 percent are graduates of foreign universities.

Of the 93 practitioners in Brandon, 35.5 percent are graduates of the University of Manitoba, 13.9 percent are graduates of other Canadian universities, and 50.6 percent are graduates of foreign universities.

Of the 350 practitioners in rural Manitoba, excluding Brandon, 43.7 percent are graduates of the University of Manitoba, 8.2 percent are graduates of other Canadian universities, and 48.1 percent are graduates of foreign universities.

TABLE IV

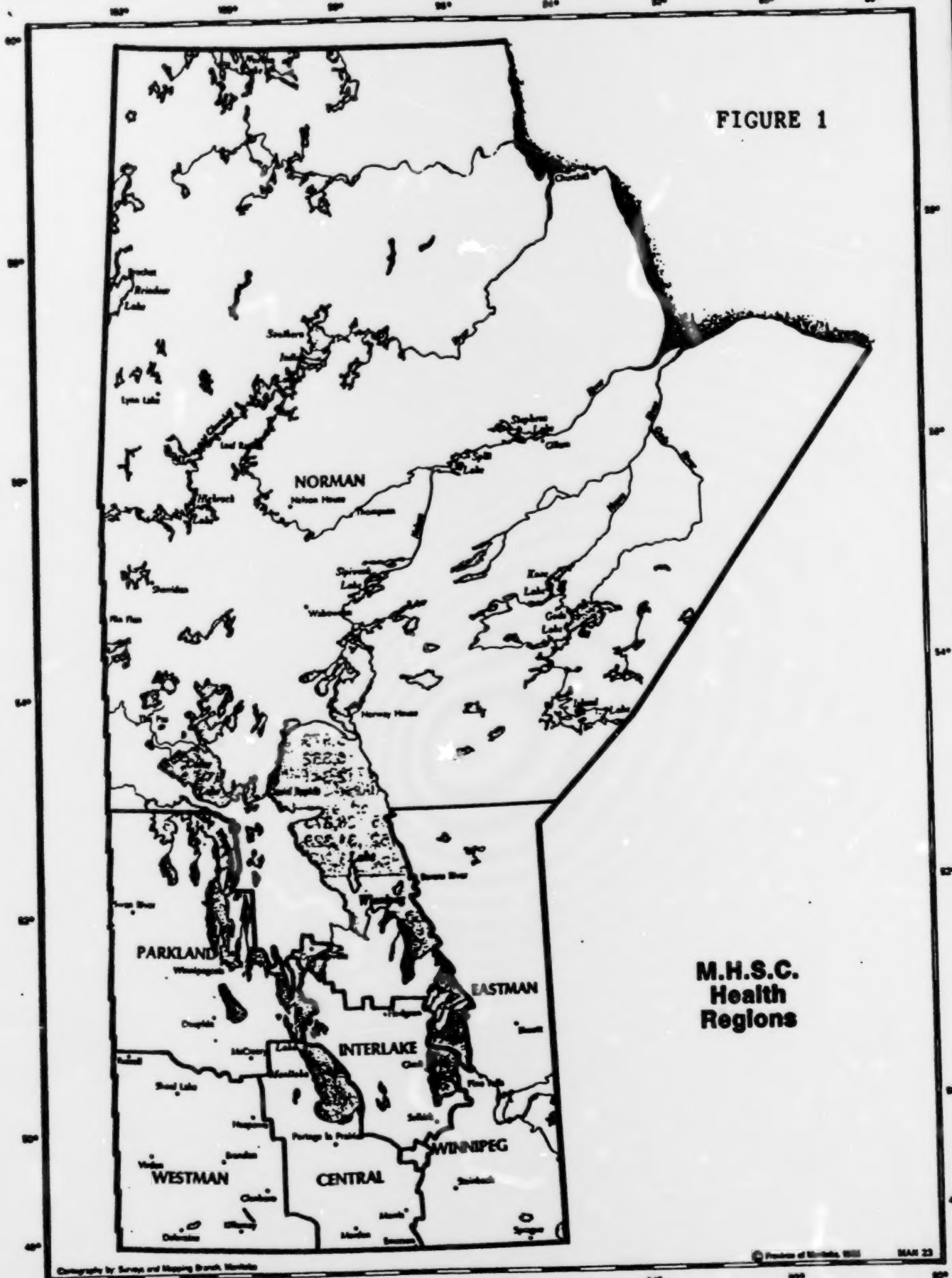
Physicians in Active Practice - December 31, 1987[4]

Region*	Population**	General and Family Physicians Rural	General and Family Physicians Urban	Specialists Rural	Specialists Urban	Total	Physician/ Population Ratio
Central	93,878	62		6		68	1/1381
Westman	119,985						1/833
(Rural)	80,249	58		1		59	1/1360
(Urban)	39,736		39		46	85	1/468****
Eastman	82,868	41		2		43	1/1927
Norman	76,784	66		3		69	1/1113***
Interlake	73,118	44		12		56	1/1306****
Parkland	49,153	34		3		37	1/1329
TOTALS	495,786	305	39	27	46	417	1/1189
Winnipeg	625,342		720		813	1,533	1/408
Manitoba	1,121,128	1,064		886		1,950	1/575
Including Residents			161			2,111	1/531

[4]Standing Committee on Medical Manpower.
*See Figure I page 11.
**Manitoba Health Services Commission registered population as of June 1, 1987
***Includes physicians employed by Northern Medical Unit.
****Includes physicians employed by Brandon Mental Health Centre - 1 psychiatrist.
Includes physicians employed by Selkirk Mental Health Centre - 6 psychiatrists.

The Standing Committee on Medical Manpower calculates that 2,111 physicians were in active practice in Manitoba as of December 31, 1987. This figure is inconsistent with the calculation of the College of Physicians and Surgeons of Manitoba, which lists 2,017 physicians in Manitoba (Table II). The College figure of 2,017 does not, however, include the 161 physicians with a residency license only. With the inclusion of these residents, the College therefore has 2,178 registered and licensed physicians in Manitoba.

FIGURE 1


NORMAN
PARKLAND
EASTMAN
INTERLAKE
WINNIPEG
WESTMAN
CENTRAL
M.H.S.C.
Health
Regions

A total of 1,064 general practitioners, 886 specialists, and 161 residents gives an overall physician to population ratio for Manitoba of 1:531.

A total of 417 physicians practice outside Winnipeg; 85 are in Brandon and 332 in rural Manitoba. Table IV shows the physician/population ratios per region and for Brandon, Winnipeg and Manitoba. The overall physician/population ratios in rural Manitoba are favourable since a population of between 1700 and 2500 is required for a viable primary care practice.

The physician/population is significantly less for rural and particularly remote areas than for urban. These numbers represent a relative abundance of physicians in Winnipeg (1:408) and Brandon (1:468) with possibly an over-representation of some disciplines and a shortage of others. It must be remembered, however, that urban physicians, particularly specialists, serve the rural as well as urban population.

WOMEN IN MEDICINE

Of all fully licenced physicians in Manitoba, 18.5 percent are women, an increase of 28 in actual numbers in the past year. In Winnipeg, women comprise 20.1 percent of all physicians, in Brandon 11.8 percent and in rural Manitoba 12.9 percent. Of all hospital residents, 24.2 percent are women. During the past six years, there has been an increase of 104 women in Winnipeg, 3 in Brandon and 1 in the remainder of the province. The increasing proportion of female practitioners may portend increasing difficulty in staffing rural practices.

TABLE V

Number of Licenced Women Practitioners in Manitoba[5]

	Winnipeg	Brandon	Rural	Total	Residency
1982	213	8	44	265	51
1883	261	12	41	314	55
1984	251	12	45	308	59
1985	273	11	47	331	57
1986	290	12	43	345	51
1987	317	11	45	373	39

[5]College of Physicians and Surgeons, Manitoba
Registrar's Report, September 18, 1987

THE NEED FOR PHYSICIANS:

As indicated in the preceding tables, the overall physician/population ratio in rural/remote Manitoba is reasonably satisfactory and in urban areas indicates an oversupply of physicians. The problem in rural Manitoba is that one vacancy in a one, two or even three doctor town constitutes a 100%, 50% or 33% reduction in medical resources: this, together with the difficulty in recruiting a locum for vacation or continuing medical education creates an urgent situation which tends to snowball as the remaining overworked physician(s) tire of the overload and leave.

The problem of oversupply of physicians in urban areas is perceived by government analysts as an unnecessary additional expense to the health care system without improving health care standards: in addition, while there is an overall oversupply, shortages exist in some disciplines, e.g., - Radiotherapy, Laboratory Medicine, Psychiatry, and Anesthesiology.

The shortages of physicians in rural and remote Manitoba have not been lessened by all the efforts of SCOMM, e.g., the Placement Bureau, the Incentive Programs and until recently, the facilitation of immigration of foreign physicians. Despite enhanced communications with the Faculty of Medicine and the Residents of the University of Manitoba concerning the need for physicians in rural areas, recruitment of local graduates has been poor. Some of the barriers to rural practise have been perceived as follows:

(a) isolation from professional colleagues

(b) overwork resulting from public demand for continuous service

(c) lack of acceptable housing

(d) limited social and cultural amenities

(e) high cost of establishing a viable practice

(f) high cost of living, particularly travel for vacations, business or professional meetings

(g) difficulty of getting a temporary replacement to permit travel or attendance at meetings

(h) lack of educational opportunities

(i) constraint on fee income and its potential for growth due to limitations of population in the catchment area

(j) lack of confidence or security to practise in a more isolated milieu, without ready access to sophisticated diagnostic and treatment resources, as well as consultation services, may reflect badly on the education and training of our graduates. Should more experience be gained during the internship and residency training in a community setting? This is particularly relevant at this time when the mandatory two year entry to practise is being considered: is the additional second year to be more of the same, e.g., tertiary care, or is it to be mainly in a community setting?

For these reasons and others, it seems our graduates prefer to practise in a saturated medical resources setting, e.g. Winnipeg, rather than in rural Manitoba. One innovation in medical services that has encouraged city practice has been the establishment of walk-in-clinics which provide many attractive features to young graduates, e.g., regular hours of work in a comparatively less stressful job, etc. It is impossible at this time to judge the benefits of these clinics since they differ greatly in programs and practise patterns and a clear definition of a " typical clinic" is required; in addition, after defining what a legitimate walk-in-clinic is, the advantages and disadvantages over other methods of practice must be analyzed. Certainly, they are adding to the physician population in Winnipeg.

Until such time as we are able to recruit University of Manitoba graduates to rural Manitoba we will be reliant on immigration of foreign medical graduates which is self defeating in the long term, since many move to the city as soon as they obtain landed immigrant status. New and

innovative approaches are required to encourage University of Manitoba graduates to practice in rural Manitoba, e.g. -

(a) Limit the number of solo practises in rural Manitoba wherever geographically possible and enhance group practises of 3 or more physicians, i.e., promote the sharing of services and resources on a regional basis. More specialists should be available to these group practises.

(b) Establish closer working relations with the University to more closely match the supply of graduates to the provincial needs. Every opportunity should be taken by the Faculty of Medicine to provide information to the students, interns and residents about rural practise and to inculcate in them some feeling of responsibility to provide the needs of rural Manitoba. Some or many of the views held by students about rural practise are not up to date.

(c) At SCOMM's request, the University (Division of Community and Northern Medicine) has submitted a plan to Manitoba Health to organize the provision of medical services to rural areas by University of Manitoba graduates. This plan should be considered as a starting point and concentrated work done on it to make it an effective and efficient component of SCOMM's overall responsibilities.

(d) Consideration of legislative action, e.g, control of billing numbers or monetary incentives/disincentives, etc., must be based on having a comprehensive, physician requirements planning process in place with information established on the number and types of physicians required throughout the province to fill the needs of the proposed new or modified delivery system.

THE URBAN OVERSUPPLY:

Although the mandate of SCOMM is to study and correct all problems in medical manpower, that is, urban as well as rural, (Ad hoc Committee, 1978), SCOMM has focused on the rural problems of shortage, since these have been acute. During the past 2-3 years there has been an increasing awareness of a subtly developing urban oversupply and a concern by government of the impact of this on costs to the health care system. In order for SCOMM to fulfill its mandate, its activities must be expanded to include the urban oversupply situation.

Several organizations, including the University (both faculty and student trainees), the Manitoba Medical Association, the College of Physicians and Surgeons, the Manitoba Health Organization, the Research and Planning Directorate of Manitoba Health, as well as SCOMM have been working on some aspect of medical manpower. Planning and progress could be more effective if these efforts were better coordinated and it could be the responsibility of SCOMM to fulfill this function including the delegation of different tasks that will be required.

Consideration should also be given at the Ministerial level to a system of coordinating the plans of different health professionals, particularly as overlap of some functions increase, e.g., the role of the primary care physician with the nurse practitioner, or the role of the nurse practitioner with the Community Health Worker (in the north).

While the problem of urban oversupply seems vastly different from the sporadic and geographically spotty rural undersupply, the solutions to both are similar in principle and involve:

(a) A clear plan of the "new health care delivery system" as it will affect both rural and urban practise patterns: this should include a policy based on a determination of the advantages and disadvantages of walk-in-clinics, for example.

(b) The development of a "physician requirement planning process" on a regional basis, to establish five year plans on the need for

the number and types of physicians in each region or unit. This should be accompanied by similar planning for other health care professionals, particularly where there is some overlap of function in some regions.

(c) Closer working relations with the University to match the supply or output of physicians with the identified provincial needs; this would include not only the number and type of graduates but an exchange of information on training, e.g., the tertiary care base of training versus the community clinic base.

(d) Immigration (both direct and indirect) will need to be controlled or the reduction in the output of University of Manitoba graduates will have no effect on the oversupply; i.e., 48.1% of physicians in rural Manitoba, 50.6% of physicians in Brandon and 29.8% of physicians now practicing in Winnipeg are graduates of foreign medical schools.

(e) If the urban oversupply problem, the geographic maldistribution problem between urban and rural areas and the shortages in some disciplines continue to increase, then legislation to correct these problems may be required, e.g., the control of billing numbers or a system of monetary incentives/disincentives, etc. If this legislation is based on a rational, comprehensive physician requirement planning process which in turn would be based on a rational revision of the health care delivery system, then, resistance to such legislation would be minimal and groundless.

SPECIALTY SERVICES TO RURAL MANITOBA:

A. Radiological Services:

Younger physicians locating in rural Manitoba are interested in providing for as many of the medical and surgical needs as is reasonably possible at the local level. This requires availability of more rapid and extensive diagnostic backup, including radiology. The mail-in of radiographs does not meet these needs and so they

request that more on-site or regional radiologists be provided. To compound this problem is the fact that some radiologists, both rural located and those who provide rural visitation services are reaching the point where they may expect to retire.

Although there is no immediate crisis, unless more radiologists willing to locate in rural Manitoba become available there may be problems ahead. The committee has approached the University of Manitoba Committee on Medical Education asking that more training slots be made available for radiologists. The committee is concerned that none of those at present in the radiology training program are intending to locate in rural Manitoba.

*See Appendix A for copy of this agreement.

B. **Psychiatric Services:**

Psychiatric services are urgently needed in the whole of Manitoba. The Career Psychiatric Program, developed by Manitoba Health, provided additional residency training positions in psychiatry for physicians prepared to serve the province on completion of training. Six psychiatrists are currently returning service and four physicians are presently participating in the program.

C. **Anesthesia Services:**

The Department of Anesthesia, University of Manitoba, has conducted a six-months anesthesia program for family physicians since 1976. The program was started because of a need, in rural Manitoba, for physicians with anesthesia training. Under it the Manitoba Health Services Commission funds up to five residency positions (ten residents at six months) a year.

From July 1980 to June 30, 1985, 28 physicians received funding under the program. Of these, 13 failed to enter rural practice on completion of their training, 15 lived up to the terms of the agreement. Of the latter, 10 are still in rural practice.

Of the 16 physicians who received funding during the period July 1, 1985 to December 31, 1987, 14 are in rural practice, one (1) is in training, and one (1) is seeking a practice site.

It is important to note that prior to July 1985, physicians receiving funding under this program were not required to sign a formal return of service agreement which probably explains the high number of "failures" during the period 1960-1985.

The Department of Anesthesia cooperates with the Standing Committee on Medical Manpower by advising applicants seeking admission to the program that they are required to sign an agreement that they will practice in rural Manitoba for twice the period funded. Failure to do so calls for reimbursement of funds provided with interest.

There has been some confusion by physicians in rural areas about the terms of the continuing medical education anesthesia training program. This has been clarified during the past year by the following information letter which was sent out to all rural physicians on December 21, 1987. The letter reads:

> "The Division of Postgraduate Medical Education (P.G.M.E.) and the Department of Anesthesia of the University of Manitoba offer 6 months postgraduate training in anesthesia for established rural physicians who wish to acquire additional skills. If the trainee desires and is able to accommodate additional training, at a later date, he/she should discuss this with the program director of the Department of Anesthesia.
>
> Upon achieving a satisfactory performance and at the end of this six month training period, a letter will be provided from the Faculty of Postgraduate Medical Education Division. In addition a letter from the College of Physicians & Surgeons will indicate the fulfillment of its requirements to administer anesthesia in rural practice.
>
> In order, however, to qualify for a certificate from the Department of Anesthesia, a further three months training is required in Anesthesia at some later time mutually convenient to the physician and the Anesthesia Department".

See Appendix B for a copy of the agreement.

INCENTIVE PROGRAMS:

The Standing Committee on Medical Manpower has in place an integrated system of incentives to encourage physicians and students to consider rural practice. The incentives also apply to selected medical specialties in which critical shortages may arise.

Rural Student Recruitment:

Since relatively few medical graduates from the University of Manitoba have entered rural practice in recent years, the Standing Committee on Medical Manpower agreed with the College of Family Physicians that recruitment promotion should be directed to rural high school students. This decision was based on the assumption that they would be more likely than urban high school students to favour rural practice on graduation.

With the cooperation of the Committee for the Promotion of Rural Practice, The College of Family Physicians of Canada, brochures promoting careers in rural medicine are made available to rural high school guidance counsellors. Counsellors also have applications from the Faculty of Medicine describing the selection process and setting out eligibility requirements. This literature is supported by posters for distribution to rural high schools and community areas frequented by students. Rural physicians cooperate by providing information and guidance on request.

Work Experience - First and Second Year Students:

The Standing Committee on Medical Manpower provides opportunities for selected first and second year medical students to gain appropriate work experience in rural and remote areas. The object is to encourage students to consider rural practice on graduation. A competitive stipend is paid to each student in addition to reimbursement for accommodation, return travel to the site and meals. Including supervision and travel, the program costs approximately $4,300 per student.

Students are instructed to gain understanding of the life and experience of a rural family physician in the office, in the community, on house calls and at home as well as in the hospital on ward rounds, in the operating theatre, in the emergency department and at committee meetings.

They are also instructed to familiarize themselves with community health facilities and health personnel such as public health nurses, social workers, health educators, mental health workers, ambulance attendants and pharmacists.

In 1987, seven students participated in the program. They and their preceptors were selected by Dr. E. Krause, Director, Undergraduate Medical Education; and Dr. G. Beazley, Professor and Head, Department of Family Medicine, Faculty of Medicine, University of Manitoba.

The students researched and wrote seven papers. The titles of these papers are:

1. A Global Look At Health Care - Carman.
2. A Report on the Role of the Allied Health Care Professional Within a Rural Community - Dauphin.
3. Role of Allied Health Care Professionals in Gladstone.
4. The Allied Health Care Services and How they Contribute to the Health Care System in Steinbach.
5. Allied Health Care Professionals in The Pas.
6. The Allied Health Care Professionals in Thompson.
7. Rural Allied Health Professionals - Virden.

Since the program was implemented, 41 students have participated. Of the 41, 7 are in practice (2 in rural Manitoba, 5 in Winnipeg); 13 are in post-graduate training, 20 in undergraduate programs, and one (1) has left medicine.

Loans to Third and Fourth Year Students:

Under this component of the incentive program, forgivable loans are offered to selected third and fourth year students provided they undertake to practice, on graduation, in a medically underserviced area.

The success or failure of the program will manifest itself within the next two years when several graduates become available for rural practice. Similar programs have been unsuccessful in some jurisdictions. A number of students withdraw because of the barriers to rural practice listed on page 13, but also because of the radical adjustment required of young physicians whose training emphasizes advanced technological procedures, sophisticated support services and highly trained auxiliary personnel. As less than one-quarter of Manitoba's loan recipients have withdrawn, there is evidently sufficient interest in the program to warrant its continuation.

Since 1981, fourty-six (46) loans were offered to a total of thirty-four (34) students. Of the thirty-four (34) students, six did not accept the loan offer, seven withdrew from the program and repaid their loans with interest. Five entered rural practice and sixteen (16) are still in training. A physician can discharge full loan obligation by serving for four years in rural Manitoba.

See Appendix C for copy of the loan agreement with the Manitoba Health Services Commission.

Family Medicine - Community Medicine Rotation:

It is obligatory for fourth year medical students to take a six to eight-weeks primary care clerkship. Over 80 percent choose to take this clerkship in rural Manitoba. The cost, paid by the University of Manitoba, is approximately $900 per student of which $400 goes to the preceptor and the remainder to the student for lodging, travel and incidental expenses.

Rural Residency Program for Practicing Physicians:

Under this program the Manitoba Health Services Commission funds positions for rural physicians to take postgraduate training courses of from one to six months in specific specialties that will broaden their skills for rural and northern practice. The Department of Continuing Medical Education, Faculty of Medicine, University of Manitoba, arranges programs to suit each individual.

In 1987, nine physicians participated in the program compared to twelve in 1986.

See Appendix D for copy of the agreement.

Family Practice Residency Program - Rural Rotation

Under this program, the Standing Committee on Medical Manpower pays transportation and accommodation expenses incurred by residents training as family physicians during their rotation period in a rural medical practice.

Since 1982, ninety-seven (97) physicians have graduated from the Family Practice Training Program at St. Boniface General Hospital. Of these, nineteen (19) are in rural Manitoba, fifty-three (53) are located in Winnipeg and twenty-five (25) have left the province. Of the thirty (30) physicians who completed the program at the Seven Oaks General Hospital during the same period (6) are in rural practice, sixteen (16) remained in Winnipeg and eight (8) have left the province.

Incentive Grants to Physicians Commencing Practice in a Designated Medically Underserviced Area:

A physician who has been approved by the Standing Committee on Medical Manpower and who establishes practice in an area designated by the Minister of Health as medically underserviced may apply for a contract with the Manitoba Health Services Commission giving him or her either a

guaranteed net income or an income-tax-free incentive grant payable over a four-year period. A medically underserviced area may be geographic or be in a specialty with a shortage of practitioners.

See Appendix E for copies of agreements.

The first establishment of practice grant was approved for a physician locating in Winnipegosis in 1981. During 1984, a specialist in internal medicine, locating in Thompson, received an establishment grant, and in 1985, two physicians establishing practice in Lynn Lake were approved. Of the latter, one physician received an establishment grant and a guaranteed net income and the second physician was offered a guaranteed income.

EVALUATION OF INCENTIVE PROGRAMS

A third year medical student was hired for a period of three months through the Summer Work Experience Program (1987) to review the incentive programs under the direction of the Secretariat. The following is an executive summary of his report. The full report is available from the Committee on request. The report was received by SCOMM during September 1987 and is under final assessment: meanwhile, some of the recommendations are being implemented. The following is the EXECUTIVE SUMMARY:

I) **Summer Work Experience**

1) Continue the program as it currently stands.

2) SCOMM should take a more active role in the direction and administration of the program

3) The program should not be expanded as of yet.

4) Reassess the program in five years.

II) **Loans to Third and Fourth Year Students**

1) The current level of funding should be maintained with changes paralleling those established by Student Aid.

2) Maintain a high level of scrutiny in the selection process.

3) Increase the advertising to get the best possible candidates.

4) Maintain better contact with recipients in order to guide them to the communities where they are most needed.

III) Continuing Medical Education

1) Maintain the program and evaluate the possibility of increasing the funding.

2) Advertise the program more fully and regularly.

3) The program should be available only to established rural physicians.

IV) Incentive Grants for Underserviced Areas

1) Expand the parameters under which underserviced is defined.

2) SCOMM should take the initiative in designating which areas are underserviced.

3) Advertise the program so that a greater number of people know of it existence.

V) Short Term Anesthesia Training

1) Fund only for the number of trainees in the course.

2) Resolve the current problem of program length.

3) Determine the actual and projected requirements for these anesthetists.

VI) Family Practise Residency - Rural Rotation

1) Decrease the funding for this program.

2) Support financially the Family Medicine's Dauphin Project.

VII) Family Medicine/Community Medicine Rural Rotation

1) Decrease the funding to a maximum of $22,500 with a move to eliminate funding entirely.

VIII) General Recommendations

1) SCOMM should take a more active role at the training level by establishing a campus based office.

2) Guide the programs more towards filling the areas of most need.

3) Evaluate the incentive programs again in five years time.

PLACEMENT SERVICE:

The Standing Committee on Medical Manpower maintains a list of communities seeking physicians. This is circulated monthly to the Faculty of Medicine, University of Manitoba; to all hospitals, and to the Professional Association of Residents and Interns of Manitoba. A complementary list of physicians seeking a practice is circulated to all communities in need of physicians.

The Secretariat visits communities in need of medical manpower to discuss local problems and assess inter-personal relationships. Experience has confirmed that effort must be made to match physician to community. The cooperation of hospital boards and community leaders must be enlisted to secure congenial circumstances and appropriate facilities for the physician proposing to establish a practice. Responsibility for obtaining a physician rests with the community.

LOCUM TENENS:

The provision of locum tenens services is an important aspect of successful recruitment and retention of rural physicians. Rural physicians require holiday relief and time off for continuing medical education.

In August 1987 a notice was placed in the College of Physicians and Surgeons of Manitoba Newsletter inviting physicians seeking locum opportunities to contact SCOMM. The notice drew little response to-date.

Monthly listings of physicians seeking locum tenens are maintained and distributed. Rural communities are provided with lists of physicians prepared to serve as locum tenens. This service complements a locum tenens service maintained by the Manitoba Medical Association and both services work together.

The Professor and Head, Department of Family Medicine, University of Manitoba and Director, Family Practice Residency Programs at the Seven Oaks General Hospital, have arranged for second year residents to serve as locum tenens for rural physicians wishing to take the Anesthesia Residency Program.

Rural physicians are still having a great difficulty recruiting Manitoba or Canadian medical graduates as locum tenens.

IMMIGRATION POLICIES:

Physician immigration is a federal responsibility. Federal authorities, however, seek agreement with the secretariat of the Standing Committee on Medical Manpower before approving physician entry to this province.

Under present policy, graduates of foreign medical schools are granted temporary entry permits for twelve months provided they are proceeding to a firm job opportunity in rural Manitoba, or a university education program.

Physicians wishing to locate as specialists may be considered for permanent entry provided their qualifications comply with the regulations of the Royal College of Physicians and Surgeons of Canada and provided they have either a university appointment or an appointment to an area of need as determined by the Standing Committee on Medical Manpower.

Before approving immigration of specialists or university appointees to Manitoba, Employment and Immigration Canada must have evidence that the position has been advertised in the Canadian Medical Association Journal, listed with the Standing Committee on Medical Manpower, and that no suitable Canadian is available.

Before 1983, foreign medical graduates from Commonwealth countries were admitted to Manitoba on the basis of their standing in their country of origin. Since August 6, 1983, however, an Order-in-Council amending The Manitoba Medical Act makes it mandatory for all immigrant physicians to pass the Medical Council of Canada Evaluating Examination before they can

be registered in Manitoba. This examination can be taken twice a year at selected Canadian Embassy centres. In 1987, the Minister of Health waived the requirement for the Evaluating Examination for up to six months for 8 graduates of foreign medical schools to perform this necessary function for physicians located north of the 53rd parallel. In view of the on-going difficulties, the Committee is considering a similar arrangement for south of the 53rd parallel.

In 1987, 38 foreign medical graduates were granted temporary entry to Manitoba for 12 months compared to 33 in 1986. Of the 38, thirteen accepted temporary appointments in rural communities compared to 12 in 1986 and served in The Pas, Boissevain, Swan River, Ste Rose du Lac, Cross Lake, Virden, Leaf Rapids, Vita, Erickson, Gillam, Lynn Lake and Thompson. In addition to the 13 in rural Manitoba, five served with the Northern Manitoba Medical Unit, 17 accepted university residency appointments and three accepted appointments in Winnipeg and Brandon.

In 1987, fifteen graduates of foreign medical schools who were granted temporary entry for positions in rural Manitoba in years prior were granted permanent immigrant status.

TABLE VI

Physician Immigration

Approved for Temporary Entry - 12 Months[6]

Year	Rural Manitoba	Northern Medical Unit	University of Manitoba Residencies	Urban Winnipeg Brandon	Total
1982	52	11	44	8	115
1983	21	7	42	12	82
1984	8	3	25	10	46
1985	14	4	13	7	38
1986	12	1	12	8	33
1987	13	5	17	3	38
		Permanent Entry-Landed Immigrant Status			
1982	2	6	2*	0	10
1983	14	2	2*	3	21
1984	7	0	3*	3	13
1985	7	1	0	2	10
1986	8	0	0	3	11
1987	15	0	0	3	18

6Standing Committee on Medical Manpower
*Staff Appointments

The number of foreign medical graduates eligible for registration and licensure in Manitoba has been affected by the introduction of the Medical Council of Canada Evaluating Examination. This requirement was supported by the Standing Committee on Medical Manpower and the Government of Manitoba. Manitoba was the last province in Canada to require it. Manitoba still does not require all foreign medical graduates to have standing in the Licentiate of the Medical Council of Canada (LMCC) which is the basic examination required of Canadian graduates and is mandatory for immigrants in most other provinces either on admission or shortly thereafter.

It is our understanding that the College of Physicians and Surgeons of Manitoba are considering making the Licencing Examination of the Medical Council of Canada (LMCC) a mandatory requirement for all practicing physicians in Manitoba.

The Standing Committee on Medical Manpower believes that immigrant physicians should meet the educational requirement and training demanded of Canadian graduates.

REFUGEE PHYSICIAN TRAINING PROGRAM:

Manitoba Health, Employment and Immigration Canada, the College of Physicians and Surgeons of Manitoba, and the University of Manitoba, Faculty of Medicine have made available a special clerkship and internship program to assist Manitoba refugee physicians.

The program is designed to provide an avenue by which trained physicians who have been uprooted from their homelands by civil strife can find career satisfaction and contribute the benefits of their past training and experience to their adopted homes. No specific demand for services is asked of these physicians, but it is hoped that they will ultimately serve Manitoba in areas of relative need.

The program, approved for a four year period in 1984, provides for an intensive, two year training period. In the first year, spaces will be provided for four physicians in a schedule of supervised clinical experience similar to the final year of medical school. The four physicians will be allowed to write the LMCC qualification examination at the same time as the 4th year students with whom they are studying. In the second year, refugee physicians who pass the LMCC and otherwise qualify will enter the regular internship program at a teaching hospital. On satisfactory completion of this second year of training, the physicians will be fully licensed for practice and subsequent specialty training. During the clerkship and internship years, candidates will be supervised and evaluated by the same process applying to regular final year students and interns in the Faculty of Medicine, University of Manitoba.

Physicians in the training program will be jointly supported by federal and provincial funding. Employment and Immigration Canada provides training allowances during the fourth year clerkship. Manitoba provides an allowance during the clerkship and funds physicians during internship.

To qualify, physicians must be proficient in English, be true residents of Manitoba, as at November 1, 1984, or be directed here as refugees by Employment and Immigration Canada, must have passed the Evaluating Examination of the Medical Council of Canada and be registered with the College of Physicians and Surgeons of Manitoba. The University of Manitoba provides limited assistance to physicians preparing for this examination.

All qualified applicants are screened by a committee of the Faculty of Medicine, University of Manitoba. Because the numbers of applicants is restricted refugee physicians landed in other Canadian provinces or territories are not eligible for the program.

STANDING COMMITTEE ON MEDICAL MANPOWER

SCHEDULE OF EXPENDITURES

FOR THE YEAR ENDED DECEMBER 31, 1987

1.	Summer Work Experience - First and Second Year Medical Students	$ 31,580
2.	Incentive Loans - Third and Fourth Year Medical Students	54,000
3.	Rural Residency Program	67,934
4.	Incentive Grants to Physicians Beginning Services in a Designated Underserviced Area	20,945
5.	Family Practice Resident's Program	14,934
6.	Administrative Costs - Quarterly meetings Travel, Advertising, etc.	5,356
7.	Family Medicine Clerkship Program	35,000
8.	Short Term Anesthesia Training Program	43,635
	TOTAL EXPENDITURE.....	$273,384

AGREEMENT FOR VISITING CONSULTANT RADIOLOGY SERVICES

RURAL HOSPITALS

THIS AGREEMENT, between

and

The _____ Hospital
_____(address)
_____

and The Manitoba Health Services Commission
Laboratory and X-Ray Services Division
599 Empress Street, Winnipeg
(hereinafter called the "Commission")

WHEREAS the Hospital requires the professional services of a consultant radiologist; and

WHEREAS the radiologist has agreed to carry out the duties and responsibilities of a radiologist at the hospital herein named, on a visiting basis; and

In consideration of these services, the radiologist will bill fees for service to the Manitoba Health Services Commission in accordance with the schedule currently in effect as published in the Physician's Manual;

IT IS HEREBY AGREED THAT:

1. The radiologist will be appointed to the hospital staff as a consultant and will have the rights and privileges pertaining thereto, and be governed by the bylaws, rules and regulations of the medical staff of the hospital;

2. Subject to By-Law number 3B under Section 40(2) of The Medical Act, the Director of a facility shall apply in the required form to the registrant of the College of Physicians & Surgeons for recognition of a facility as an approved faculty.

3. That the radiologist will attend at the hospital for the purpose of carrying out his duties and responsibilities once in each week on a day mutually agreed upon by the radiologist, the medical staff, and the hospital administration. (Details in this Section should express the specific arrangements that have been agreed upon).

4. A mail-in interpretation service or the use of technical transmission devices may be agreed upon if there are not procedures to be done at the hospital that require the presence of the radiologist; it being provided that the radiologist will attend at the hospital at least once in each year to review the organ imaging facilities.

...2

5. In addition to his professional services in the supervision and carrying out of organ imaging procedures and their interpretations, the radiologist will make himself available on a mutually agreeable schedule for consultation with local physicians; he will provide appropriate professional direction and education for the technical staff; and he will make recommendations in writing to the hospital administration and the director of the laboratory and x-ray division of the Manitoba Health Services Commission with respect to those things that in his opinion would improve the operation of the organ imaging services in the hospital.

6. If the radiologist is unable, on occasion, to personally attend at the hospital, it is agreed that he will try to supply a substitute, and this will be acceptable to the hospital on a temporary basis.

7. If the radiologist does his interpretations and dictates his reports on site, the hospital will supply the secretarial service for typing these reports. If the interpretations are done elsewhere, the secretarial service is the responsibility of the radiologist, since his consultant reports are required to be supplied to the physician and the hospital in writing.

8. The term of this agreement is two years from the date of its signing, and shall remain in force and effect from year to year thereafter, unless written notice to the contrary is given by any one of the three parties hereto, subject to item 9.

9. Notice of termination of this agreement may be given by any one of the three parties to it by notice sent by registered mail to the other parties not less than 12 months before the requested termination date. The time limits may be altered by mutual agreement between all three parties.

10. IN WITNESS WHEREOF the parties hereto have executed this agreement on the _____day of _____, 19___.

_____	_____
Witness	Physician
_____	_____
Witness	The Hospital
_____	_____
Witness	Executive Director Manitoba Health Services Commission

APPENDIX B

SHORT TERM ANESTHESIA TRAINING PROGRAM

MEMORANDUM OF AGREEMENT

THIS AGREEMENT is made in duplicate BETWEEN:

_____ M.D.

_____
(hereinafter called the "physician")

OF THE FIRST PART

-and-

The Manitoba Health Services Commission
(hereinafter called the "Commission")

OF THE SECOND PART

In consideration of six months funding under the Family Practice Anesthesia Training Program at the University of Manitoba, IT IS HEREBY AGREED THAT:

1. Upon completion of this training, the physician shall

   (a) proceed expeditiously to enter into the practice of medicine in an approved rural community in Manitoba, or

   (b) Immediately repay to the Commission the entire amount funded to him/her under this Agreement, net of income tax paid, together with interest thereon at the rate provided for in this agreement.

FORGIVENESS OF AMOUNT FUNDED

2. (a) Beginning on the date in which the physician commences practice in an approved rural community in Manitoba designated by the Commission, the obligation for repayment of the amount funded pursuant to this Agreement shall be forgiven at the rate equivalent to one month residency funding for every two months that the physician continues to practice in the approved rural community.

   (b) Should the physician cease to practice in an approved rural community in Manitoba prior to the entire amount funded being forgiven, then the balance of the amount funded shall immediately be due and payable, together with interest accrued thereon.

...2

INTEREST ON LOAN

3. (1) If the physician continues to practice in an approved rural community of Manitoba designated by the Commission for a sufficiently long period of time such that the principal amount funded is entirely forgiven, then the interest chargeable on the amount funded shall be totally forgiven;

(2) To the extent that the principal amount funded is not forgiven through the remission schedule specified in Section 2, interest shall accrue on the funds advanced pursuant to this Agreement from the date that they are advanced to the physician;

(3) For the purposes of determining interest payable, the earliest funds advanced to the physician under the terms of this Agreement shall be the first to be forgiven by practice in an approved rural community in Manitoba designated by the Commission;

(4) The rate of interest on all monies advanced under the terms of this Agreement shall be equivalent to the prime lending rate charged by chartered banks in Winnipeg on the date that the physician becomes obliged under terms hereof to make repayment to the Commission.

4. A physician in receipt of funding under the Short Term Anesthesia Training Program shall not claim fee-for-service for any services he/she may provide in that field of practice in the hospital in which training is received during the period of funding.

IN WITNESS WHEREOF the parties have executed this agreement on the _____ day of _____, 19___.

_____ _____ _____

Witness Physician

_____

Executive Director
Manitoba Health Services Commission

APPENDIX C

- MEDICALLY UNDERSERVICED AREAS - PROVINCE OF MANITOBA - LOANS THIRD AND FOURTH YEAR STUDENTS - FACULTY OF MEDICINE MEMORANDUM OF AGREEMENT

THIS AGREEMENT made in duplicate BETWEEN

_____

_____

(hereinafter called the "student"),

OF THE FIRST PART,

- and -

THE MANITOBA HEALTH SERVICES COMMISSION
(hereinafter called the "Commission"),

OF THE SECOND PART.

In consideration of a loan of $_____ of which $_____ will be advanced on the execution of this Agreement and the balance on _____ and the mutual covenants and agreements contained in this agreement, the parties agree as follows:

1. It is an express condition precedent to this Agreement that the student is in good standing and enrolled in the _____ year of the program of the Faculty of Medicine of the University of Manitoba leading to a degree of Doctor of Medicine.

2. Upon graduating from the University of Manitoba with a degree of Doctor of Medicine and completing the service in Manitoba in an intern capacity necessary in order to be eligible for registration with the College of Physicians and Surgeons of Manitoba, the student shall:

   (a) immediately apply to be registered with the College of Physicians and Surgeons of Manitoba and within 3 months of being so registered commence practice in a medically underserviced area of Manitoba designated by the Commission; or

   (b) enter into post-internship training in Manitoba, not to exceed 2 years in length unless approved by the Standing Committee on Medical Manpower, and within 3 months of completion of same commence practice in a medically underserviced area in Manitoba designated by the Commission. A student is only entitled to follow this course of action if, prior to entering into post-internship training, he has provided the Commission with written confirmation that the Standing Committee on Medical Manpower is of the opinion that the post-internship training fulfills the intent of the incentive program; (If the post-internship training is to be in family practice, then the student shall not be obliged to obtain the written confirmation from the Standing Committee on Medical Manpower); or

   (c) immediately repay to the Commission the entire amount loaned to him or her under the terms of this agreement, together with interest thereon at the rate provided for in this agreement.

...2

3. If the student is unable to follow the course of action outlined in clause 2(b) because the Standing Committee on Medical Manpower is of the opinion that the post-internship training proposed by the student is not consistent with the intent of the incentive program; then the student shall forthwith follow either of the courses of action set forth in clause 2(a) or 2(c).

FORGIVENESS OF LOAN

4. Beginning on the date on which the student commences practice in a medically underserviced area of Manitoba designated by the Commission, the obligation for repayment of the loan made pursuant to this Agreement shall be forgiven at the rate of $1125 for every 3 months that the student continues to practice in the medically underserviced area.

5. Should the student:

   (a) fail within a reasonable time to graduate from the University of Manitoba with a degree of Doctor of Medicine, or to complete the internship necessary in order to be registered with the College of Physicians and Surgeons of Manitoba; or

   (b) pursuant to clause 2(b) enter upon post-internship training and fail to successfully complete same; or

   (c) cease to practise in the designated medically underserviced area in Manitoba prior to the entire loan being forgiven;

   then, the balance of the loan shall immediately be due and payable, together with interest accrued thereon.

INTEREST ON LOAN

6. (1) If the student continues to practice in the medically underserviced area of Manitoba designated by the Commission a sufficiently long period of time such that the principal amount of the loan is entirely forgiven, then the interest chargeable on the amount loaned shall be totally forgiven;

   (2) To the extent that the principal sum of the loan(s) is not forgiven through the remission schedule specified in Section 4, interest shall accrue on the funds loaned pursuant to this Agreement from the date that they are advanced to the student;

   (3) For the purposes of determining interest payable, the earliest funds advanced to the student under the terms of this Agreement shall be the first to be forgiven by practice in a medically underserviced area in Manitoba designated by the Commission;

   (4) The rate of interest on all monies loaned under the terms of this Agreement shall be equivalent to the prime lending rate charged by chartered banks in Winnipeg on the date that the student becomes obliged under terms hereof to make repayment to the Commission.

NOT CONTRACT OF EMPLOYMENT

7. The student and the Commission agree that this Agreement does not constitute a contract of employment.

...3

ALTERNATE AREA OF PRACTICE OR SERVICE

8. In the event that there is no area of the Province of Manitoba designated as medically underserviced at the time the student is ready to enter practice, the Commission shall specify an alternate area of the Province in which to practice or an alternate form of service that will qualify for remission under the terms hereof. Should the student not wish to accept the alternatives presented by the Commission, then, the entire amount of the loan together with interest thereon shall be due and payable to the Commission, and the student shall forthwith make payment of same to the Commission.

NOTICE

9. Where notice is required to be given under the terms of this Agreement it shall be in writing and delivered or sent by registered mail to the Commission at the following address:

Box 925
599 Empress Street
Winnipeg R3C 2T6

or, to the student at the following address:

_____
_____
_____

The student shall, not later than 3 months after obtaining his degree of Doctor of Medicine from the University of Manitoba send to the Commission notice indicating which of the alternatives set forth in paragraph 2 hereof, he/she intends to select. If the student subsequently wishes to select another alternative, he/she shall forthwith send the Commission notice of his/her intention to do so.

COMMISSION TO DESIGNATE AREAS OF PROVINCE

10. The Commission subject to paragraph 8 shall designate medically underserviced areas in the Province. Where more than one medically underserviced area has been designated, then the student shall have the right to select his/her preference.

REDUCTION IN ESTABLISHMENT OF PRACTICE GRANT

11. The student acknowledges that the maximum amount of any subsequent establishment of practice grant shall be reduced by a sum equivalent to the amount of monies loaned under the terms hereof.

IN WITNESS WHEREOF the parties hereto have executed this Agreement on the _____ day of _____, 19___.

_____ _____
Witness Student

_____
Executive Director
MANITOBA HEALTH SERVICES COMMISSION

APPENDIX D

GRANTS IN AID OF SHORT TERM TRAINING

RURAL RESIDENCY PROGRAM
STANDING COMMITTEE ON MEDICAL MANPOWER

THIS AGREEMENT made in duplicate BETWEEN:

_____, M.D.
_____

(hereinafter called the "physician") OF THE FIRST PART

- and -

The Manitoba Health Services Commission
(hereinafter called the "Commission") OF THE SECOND PART

HEREBY AFFIRMS THAT:

1. The physician has applied to the Standing Committee on Medical Manpower, representing the Manitoba Health Services Commission to provide payment to him/her for a period of _____ months under the terms of the Rural Residency Program, to take post-graduate training at the University of _____, consisting of:

_____ _____
(Course) (Duration)

2. And he/she has agreed that on completion of this training he/she will proceed expeditiously to enter into the practice of medicine at _____.

3. The physician has applied to the Standing Committee on Medical Manpower for financial support under the Rural Residency Program by way of a stipend for a period not exceeding six months, payable monthly at the rate of $_____ per month.

4. The Standing Committee on Medical Manpower has approved this training and will grant the financial support as requested by the physician with the first payment payable on or about _____.

...2

5. Beginning on the day on which the physician commences to practice medicine in an approved rural community in Manitoba the grant made under this agreement will be forgiven at a rate of $1,249.22 of the total grant each month during the continuance of the practice, until it is fully forgiven.

6. Should Dr. _____ cease to practice in the approved rural community before the amount of the grant is fully forgiven, the portion remaining shall be immediately due and payable, together with interest on the unpaid balance from the date of the first stipendiary payment under the grant until the date of repayment, at the prime bank loan rate in Winnipeg on the settlement date.

7. A physician in receipt of funding under the Rural Residency Program shall not claim fee-for-service for any services he/she may provide in that field of practice in the hospital in which training is received during the period of funding.

8. In Witness Whereof the parties hereto have executed this Agreement on the _____ day of _____, 19___.

_____
Witness

_____
Physician

_____
Executive Director
MANITOBA HEALTH SERVICES COMMISSION

APPENDIX E

MANITOBA HEALTH SERVICES COMMISSION
INCENTIVE PROGRAM FOR PHYSICIANS
MEDICALLY UNDERSERVICED AREAS
PROVINCE OF MANITOBA

ESTABLISHMENT OF PRACTICE AGREEMENT

This Agreement made in duplicate

BETWEEN:

THE MANITOBA HEALTH SERVICES COMMISSION
(hereinafter called the "Commission"),
OF THE FIRST PART'

- and -

_____
(hereinafter called the "Practitioner"),
OF THE SECOND PART.

This Agreement witnesseth that, subject to the terms and conditions hereinafter set out, the parties hereto agree as follows:

TERM OF AGREEMENT

1. The term of this Agreement shall be a period of 12 months from the date that the Practitioner begins to practice in the medically underserviced area in Manitoba designated by the Commission under the terms hereof.

PAYMENT TO PRACTITIONER

2. The Commission agrees:

(a) to pay to the Practitioner the sum of $_____ every 3 months during the term of this Agreement and the term of any renewal thereof, beginning 3 months from the date on which the Practitioner commences practice in the medically underserviced area in Manitoba designated by the Commission under the terms hereof.

(b) the total amount paid to the Practitioner by the Commission under the terms of this Agreement and any renewal thereof shall not exceed the sum of $_____.

3. The Practitioner agrees:

(a) to commence practice on the _____ day of _____ in the medically underserviced area of the Province designated by the Commission and more particularly described as follows:

_____

_____

(b) to continue to practice on a full-time basis in the medically underserviced area described above for the term of this Agreement and any renewal thereof.

(c) that if the Practitioner receives grant monies paid pursuant to this Agreement and fails to continue to practice on a full-time basis as required under the terms of this Agreement, for the period in regard to which the grant monies were paid, those monies shall constitute a debt due and owing to the Manitoba Health Services Commission and shall be repayable to the Commission upon demand.

...2

VACATION TO BE INCLUDED AS PART OF CONTINUOUS PRACTICE

4. The parties agree that the Practitioner shall be entitled during the term of this Agreement and any 12 month renewal thereof, to take a vacation not exceeding 4 weeks, without having that vacation construed as an interruption with the Practitioner's obligation to practice on a continuous basis.

TERMINATION OF AGREEMENT

5. The Practitioner agrees that the Commission shall have the right to terminate this Agreement on 30 days notice where the Commission has decided that the manner in which the Practitioner is conducting his practice is not satisfactory. Prior to making a decision as to whether the service provided by the Practitioner is satisfactory, the Commission shall first consider a report and recommendation from a committee of not less than 3 persons appointed by the Chairman of the Standing Committee on Medical Manpower established at the request of the Commission. It shall be the obligation of the committee to make the report after due inquiry into the matter of the manner in which the Practitioner was conducting his practice.

NOT CONTRACT OF EMPLOYMENT

6. The parties agree that this Agreement does not constitute a contract of employment of service and that it is solely an Agreement to provide for the establishment of practice incentive grant funds to the Practitioner on fulfillment of the Agreement and covenants contained herein.

EARLY TERMINATION BY MUTUAL CONSENT

7. The parties hereto may, by mutual agreement, terminate this Agreement at any time. Should either party wish to terminate the Agreement, it shall give notice of its desire to do so to the other party. The other party shall then consider the request and give notice as to whether it is willing to terminate the Agreement and, if so, on what basis.

NOTICE

8. Where notice is required to be given pursuant to the terms of this Agreement it shall be in writing and sent by registered mail or delivered:

to the Commission at:

Manitoba Health Services Commission
599 Empress Street
Winnipeg, Manitoba
R3C 2T6

to the Practitioner at:

_____
_____ ("address")

_____ _____

Witness Practitioner

MANITOBA HEALTH SERVICES COMMISSION

Per: _____

AGREEMENT FOR GUARANTEED ANNUAL NET PROFESSIONAL INCOME

MEDICAL

THIS AGREEMENT made in duplicate

BETWEEN:

MANITOBA HEALTH SERVICES COMMISSION
(hereinafter referred to as the "Commission"),

OF THE FIRST PART

- and -

a legally qualified medical practitioner in Manitoba
(hereinafter referred to as the "Practitioner"),

OF THE SECOND PART

WHEREAS the Practitioner has agreed to establish or to join a private general practice in medicine on a full-time basis for the purpose of providing medical services to the public in an area designated by the Commission as an underserviced area;

AND WHEREAS the Commission has agreed to guarantee the Practitioner a net professional income of per annum to be derived from his medical practice in accordance with the provisions of this Agreement;

NOW THIS AGREEMENT WITNESSETH that in consideration of the mutual covenants and agreements hereinafter contained the parties hereto mutually covenant and agree as follows:

1. (1) The Practitioner shall prior to establishing his private general medical practice or joining a general practice hereinafter referred to as "the practice" submit to the Commission the following information:

   (a) details of his proposed total staff and the salaries to be paid to them;

   (b) details of the office equipment and furnishings required for the practice;

   (c) the amount of rent for the office; and

   (d) details of the vehicle used in the practice.

...2

(2) The Practitioner shall obtain the written approval of the Commission prior to making any legal commitment to hire staff and to entering into any arrangement for office accommodation and equipment.

2. The Practitioner will practice at _____ and he will be solely and completely responsible for all matters arising out of or resulting from his practise of medicine.

3. (1) The Commission in its discretion may make an advance payment to the Practitioner during the term of this Agreement.

(2) The advance payment shall be repaid by the Practitioner at the expiration or termination of this Agreement, or the amount of the advanced payment may be set off against any claim made by the Practitioner respecting the guaranteed net professional income as agreed herein.

4. The Commission and the Practitioner agree:

(a) that all fees or accounts receivable arising out of the practice are payable to and are the sole property of the Practitioner;

(b) that all debts and liabilities arising out of the practice are the sole responsibility and liability of the Practitioner; and

(c) that the proprietary interest in and the liability of the practice are vested solely in the Practitioner.

5. (1) The Practitioner shall:

(a) maintain a daily journal and he shall record therein the particulars of the professional services provided by him;

(b) maintain accurate and current financial records of all accounts rendered for professional services and the amounts received in payment thereof;

(c) maintain accurate and current records of all business transactions related to the practice;

(d) maintain a separate bank account for these purposes;

(e) submit his accounts for professional services rendered to the Commission or its successor;

(f) submit to the Commission for each of the first 5 months of the term of this Agreement statements of receipts and payments; and

(g) submit to the Commission at the end of the Agreement year, financial statements respecting the practice.

...3

(2) The Practitioner covenants that all financial records and business transactions of the practice shall be open for inspection at all reasonable times by the Commission or any agent it designates.

(3) The Practitioner agrees that all financial records and books of account will be subject to audit by the Financial Officers of the Commission before final settlement is made.

6. (1) The Commission and the Practitioner agree that the Practitioner's annual professional income and expenditures shall be calculated on an accrual basis and that any inventory shall be evaluated and included in the calculation of the annual professional income.

(2) The Commission and Practitioner agree:

(a) that the Practitioner's annual net professional income shall be calculated on the Practitioner's gross total professional income less authorized practice expenses and deductions;

(b) that the Commission or any agent it designates retains the right to disallow any expenses and deductions which in the opinion of the Commission appear excessive or unreasonable having regard to the nature of the practice; and

(c) convention and course expenses will be subject to the provision specified in clause b of sub-section 2 of section 6 and receipts for these will be required.

(3) The Commission agrees, at the expiration of the term of this Agreement to pay to the Practitioner the audited difference between the Practitioner's net professional income as calculated herein and such a sum as to ensure a guaranteed net professional income to the Practitioner of _____.

(4) The Commission agrees that the Practitioner is entitled to an annual vacation of four weeks during the term of this Agreement.

(5) This Agreement is for a term of one year commencing on _____ _____ and ending on _____.

(6) Where this Agreement is terminated under the provisions of subsection 7(1) or subsection 7(2) the Commission shall have no obligation to make any payment to the Practitioner regarding the guarantee of his professional income, except for payments made pursuant to section 8.

...4

7. (1) The Commission and the Practitioner agree that this Agreement may be terminated by the Commission on thirty days written notice to the Practitioner where:

   (a) false statements are made in any documents or records required of the Practitioner;

   (b) following a review and report prepared on the request of the Commission, by an ad hoc committee appointed by the Chairman of the Standing Committee on Medical Manpower, the Commission is of the opinion that the services rendered to the Practitioner's patients are not satisfactory or the business or the professional conduct of the Practitioner is not satisfactory;

   (c) the Practitioner does not comply with the terms of this Agreement.

   (2) The Commission and the Practitioner further agree that this Agreement shall become null and void where:

   (a) the Practitioner becomes bankrupt; or

   (b) the Practitioner is found to be guilty of professional misconduct; or

   (c) the Practitioner's license to practice is suspended or cancelled; or

   (d) the Practitioner becomes disabled through illness, accident or any cause whatsoever so as to be unable to provide full-time professional services in the designated area for a period of two consecutive months.

   (3) The written notice of termination of this Agreement shall be sent by registered mail to the Practitioner at his office address and such notice shall be deemed to have been received on the fifth day after the date of mailing.

8. Where this Agreement has been voided under clause 7(2)(d) the Commission shall pay to the Practitioner a sum that shall be prorated on a monthly basis in such amount as the sum of _____ per annum bears to the number of months of service rendered by the Practitioner under this Agreement.

9. The Minister and the Practitioner mutually acknowledge that this Agreement is not a contract of employment nor is to be construed as such.

...5

10. The Minister and the Practitioner agree that the monetary rights secured hereunder are unassignable except with the prior written consent of the Commission or any agent he designates.

IN WITNESS WHEREOF the Parties hereto have executed this Agreement on the

_____ day of _____.

SIGNED, SEALED AND DELIVERED in the presence of

MANITOBA HEALTH SERVICES COMMISSION, as represented by:

_____

The PRACTITIONER

_____